FORENSIC & JUVENILE SERVICES INVOICE SUMMARY

Community Mental Health Center: _____

Center #: _____ CMHC Forensic Coordinator: _____

Date of Invoice: _____

Service Provided	Total Number of Claims Submitted	Total Amount Billed	Total Amount Approved for Payment by TDMH (For TDMH use only)
Forensic (adult)			
Juvenile			
Competency Training/Maintenance			
Other Services (Specify)			
Month Total:			
YTD Total:			

_____ _____ _____

Person Submitting Claims (Please Print) | Phone Number | Date

TDMH Forensic Services Approval | Date